

(1) Cosmetic surgery or other treatment for cosmetic purposes except to restore bodily function or correct deformity resulting from disease.

(2) Custodial care except for hospice care associated with the palliation of terminal illness.

(3) In vitro fertilization, artificial insemination or any other artificial means used to cause pregnancy.

(4) Abortion services except when the life of the woman would be endangered or when the pregnancy is the result of an act of rape or incest.

(5) Experimental care except as part of an FDA-approved clinical trial.

§ 152.20 Prohibitions on pre-existing condition exclusions and waiting periods.

(a) *Pre-existing condition exclusions.* A PCIP must provide all enrollees with health coverage that does not impose any pre-existing condition exclusions (as defined in § 152.2) with respect to such coverage.

(b) *Waiting periods.* A PCIP may not impose a waiting period with respect to the coverage of services after the effective date of enrollment.

§ 152.21 Premiums and cost-sharing.

(a) *Limitation on enrollee premiums.* (1) The premiums charged under the PCIP may not exceed 100 percent of the premium for the applicable standard risk rate that would apply to the coverage offered in the State or States. The PCIP shall determine a standard risk rate by considering the premium rates charged for similar benefits and cost-sharing by other insurers offering health insurance coverage to individuals in the applicable State or States. The standard risk rate shall be established using reasonable actuarial techniques, that are approved by the Secretary, and that reflect anticipated experience and expenses. A PCIP may not use other methods of determining the standard rate, except with the approval of the Secretary.

(2) Premiums charged to enrollees in the PCIP may vary on the basis of age by a factor not greater than 4 to 1.

(b) *Limitation on enrollee costs.* (1) The PCIP's average share of the total allowed costs of the PCIP benefits must be at least 65 percent of such costs.

(2) The out-of-pocket limit of coverage for cost-sharing for covered services under the PCIP may not be greater than the applicable amount described in section 223(c)(2) of the Internal Revenue code of 1986 for the year involved. If the plan uses a network of providers, this limit may be applied only for in-network providers, consistent with the terms of PCIP benefit package.

§ 152.22 Access to services.

(a) *General rule.* A PCIP may specify the networks of providers from whom enrollees may obtain plan services. The PCIP must demonstrate to HHS that it has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible to its enrollees.

(b) *Emergency services.* In the case of emergency services, such services must be covered out of network if:

(1) The enrollee had a reasonable concern that failure to obtain immediate treatment could present a serious risk to his or her life or health; and

(2) The services were required to assess whether a condition requiring immediate treatment exists, or to provide such immediate treatment where warranted.

Subpart E—Oversight

§ 152.26 Appeals procedures.

(a) *General.* A PCIP shall establish and maintain procedures for individuals to appeal eligibility and coverage determinations.

(b) *Minimum requirements.* The appeals procedure must, at a minimum, provide:

(1) A potential enrollee with the right to a timely redetermination by the PCIP or its designee of a determination regarding PCIP eligibility, including a determination of whether the individual is a citizen or national of the United States, or is lawfully present in the United States.

(2) An enrollee with the right to a timely redetermination by the PCIP or its designee of a determination regarding the coverage of a service or the amount paid by the PCIP for a service.

(3) An enrollee with the right to a timely reconsideration of a redetermination made under paragraph (b)(2)